Improving Health Care Quality and Cost
State of Washington

January 2006

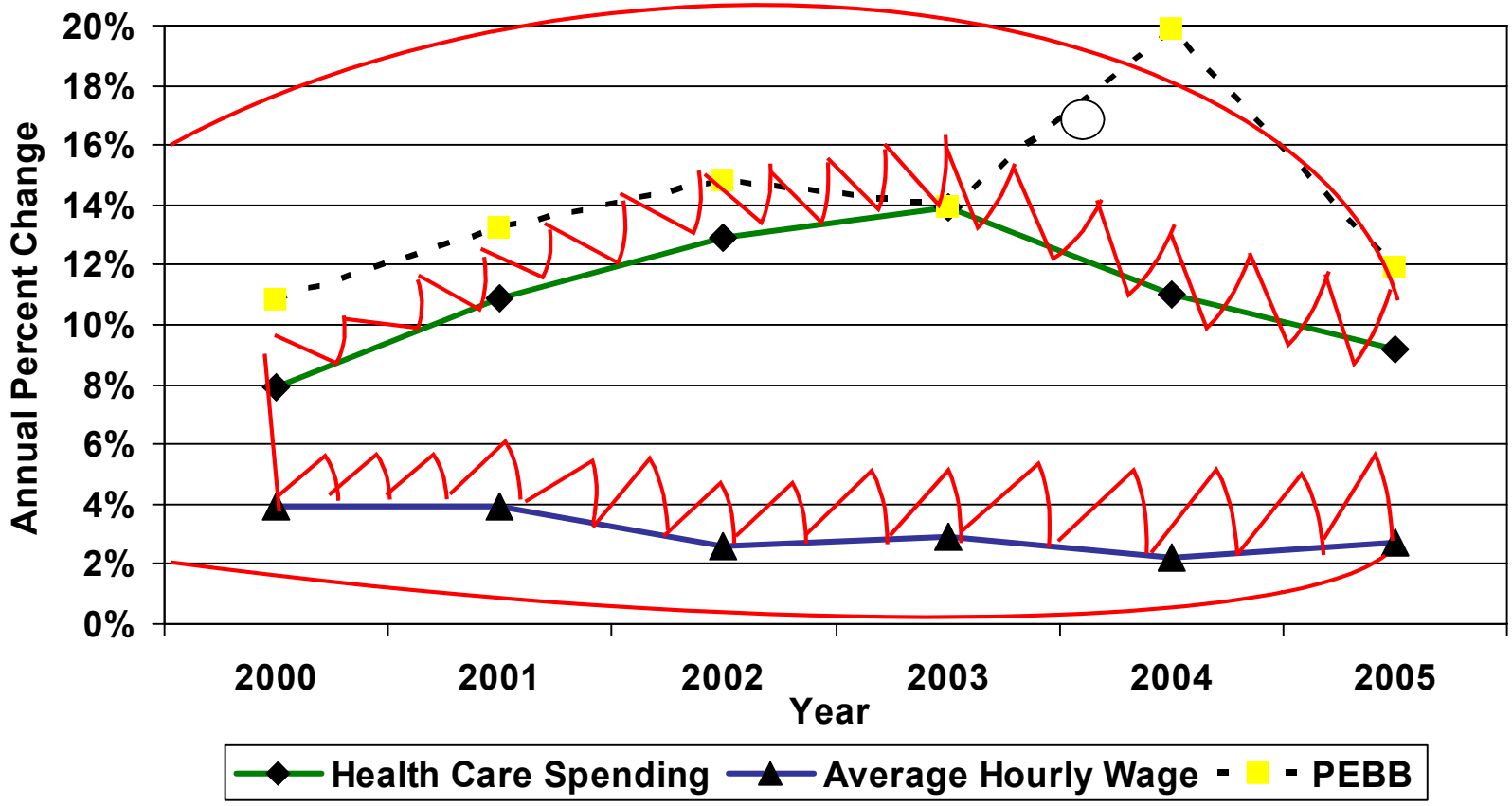
Governor's Work Group on Health Care Quality and Cost—Project Scope

- **A coordinated, statewide approach to corralling health care costs**
  - Reduce rate of health care cost growth for State government
  - Reduce rate of health care cost growth for businesses in the State
- **Look at everything possible that can:**
  - Improve quality
  - Lower costs
  - Increase access
- **Make specific recommendations that:**
  - Can be implemented under current law
  - Call for legislation next session
  - Can be advocated by the Governor—changes in the broader system and federal government
- **Charge:**
  - Do not cut the number of people covered by State programs
  - Take risks
  - Be innovative
  - Develop public-private partnerships

Meet the Shark

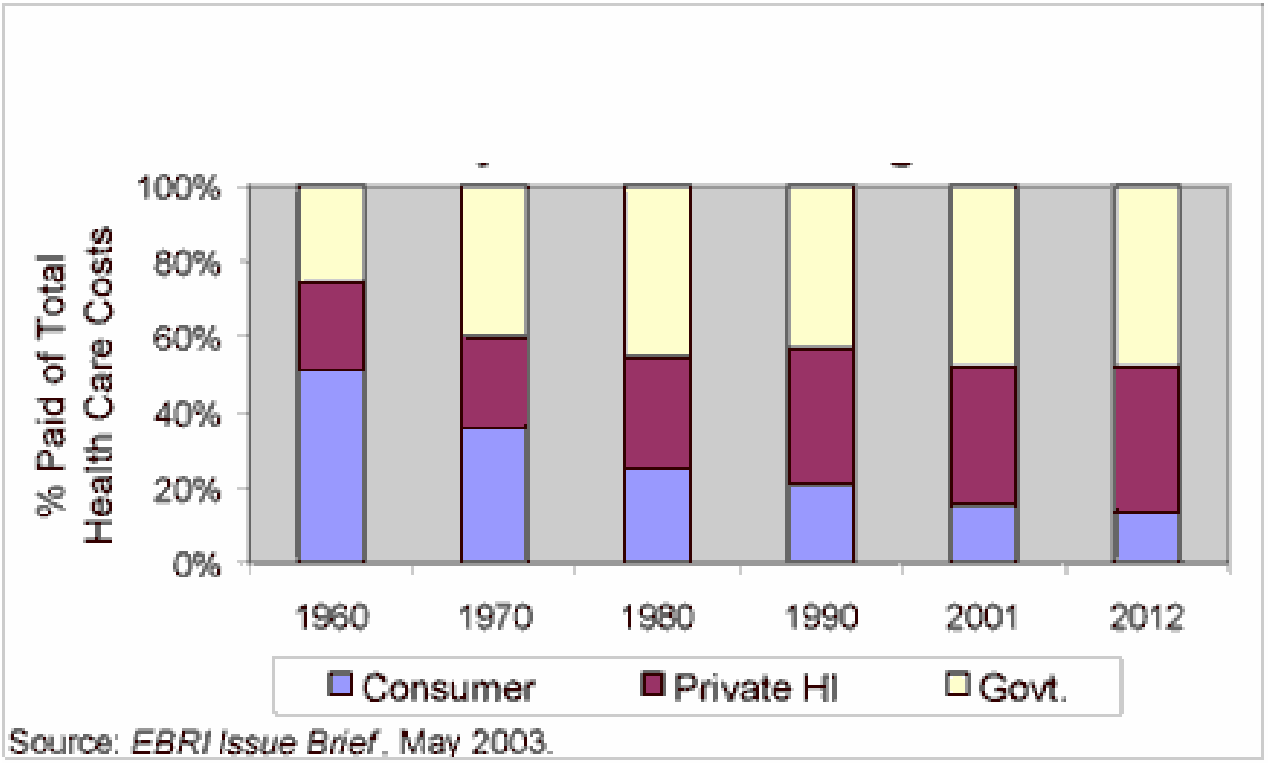
Outswim It or Spend >50% of Employee and Retiree Income on Health Care

Annual Percent Changes per Capita in Health Care Expenditures and in Average Hourly Wages for Workers in All Industries, 2000 through 2005. Average annual incremental benefit = 44 days of good quality life.



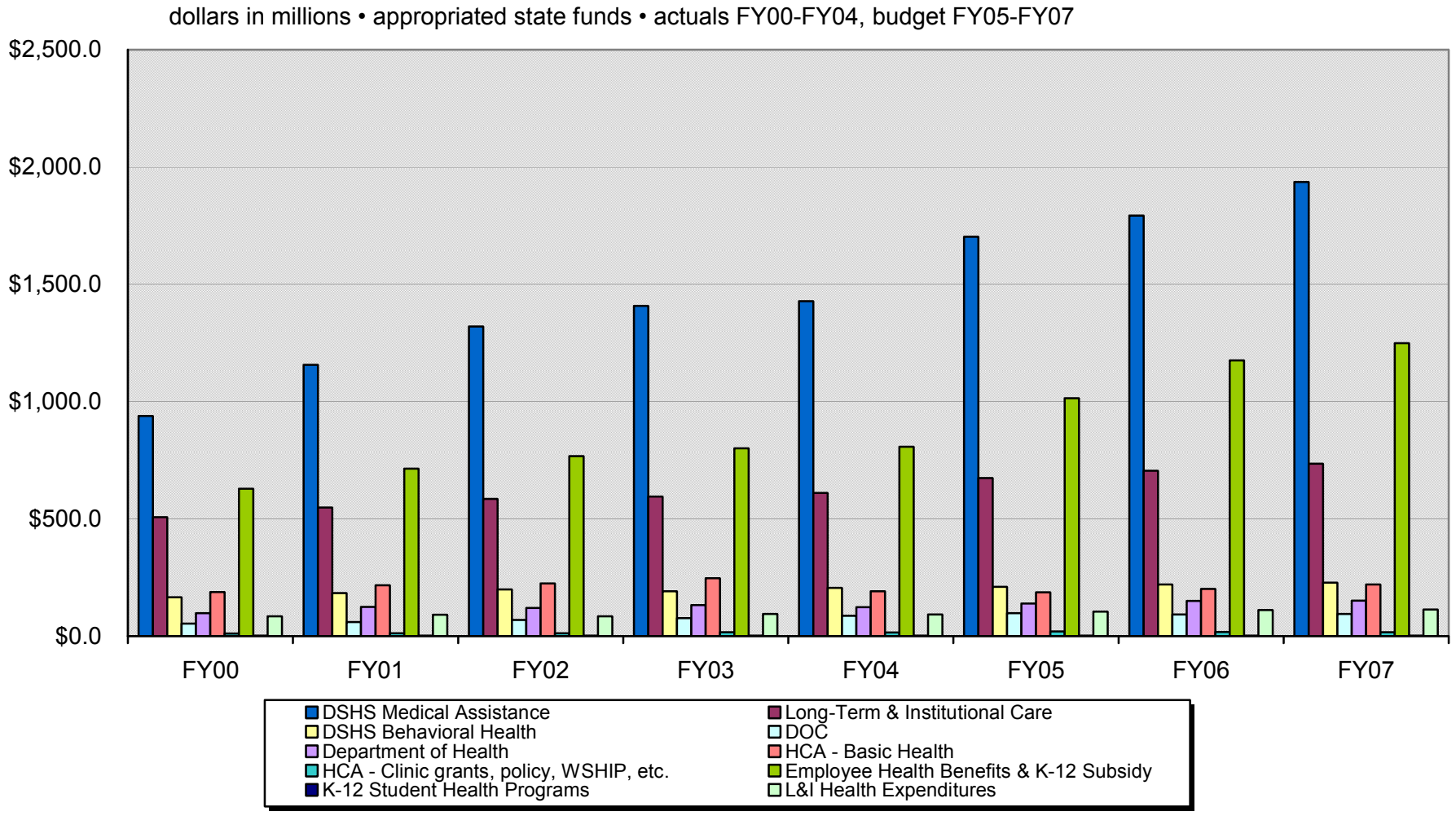
Data from Kaiser Permanente/Health Research & Educational Trust 2005. Dental work by Dr. Milstein.

Employer and Government Share Is Increasing



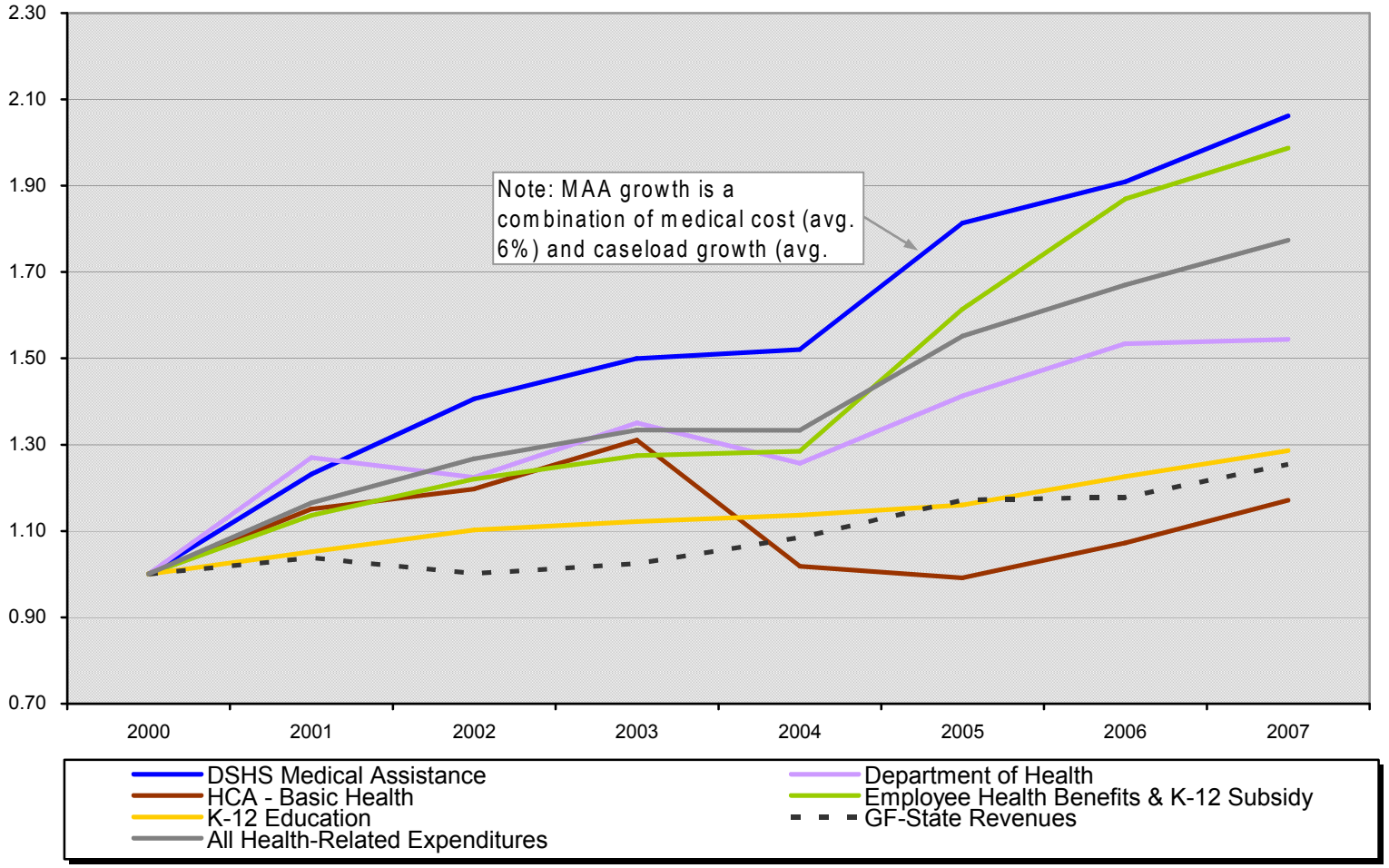
Source: *EBRI Issue Brief*, May 2003.

Washington State Health Expenditures



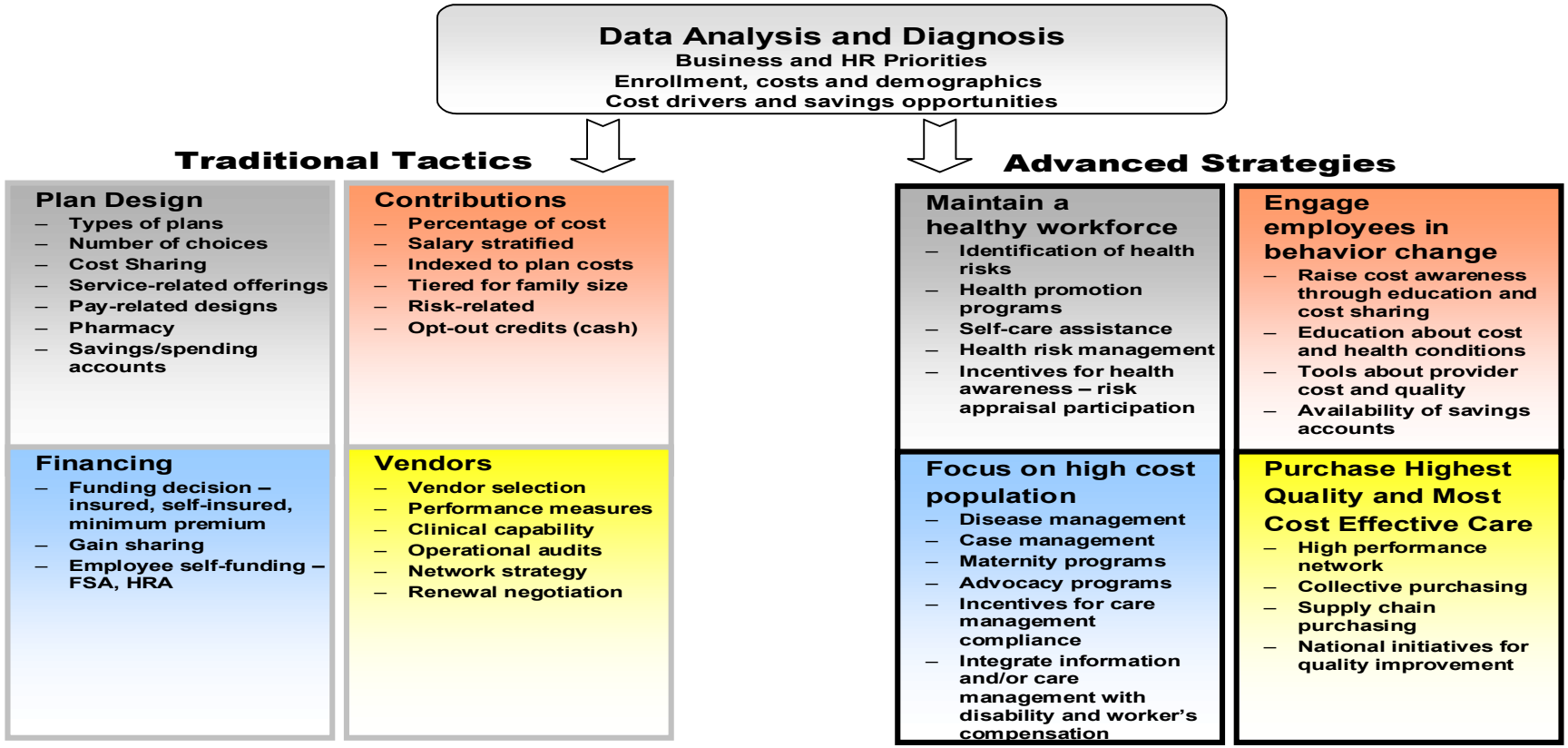
Source: State of Washington Office of Financial Management (July 2005)

Growth in Selected Costs versus Growth in General Fund-State Revenue



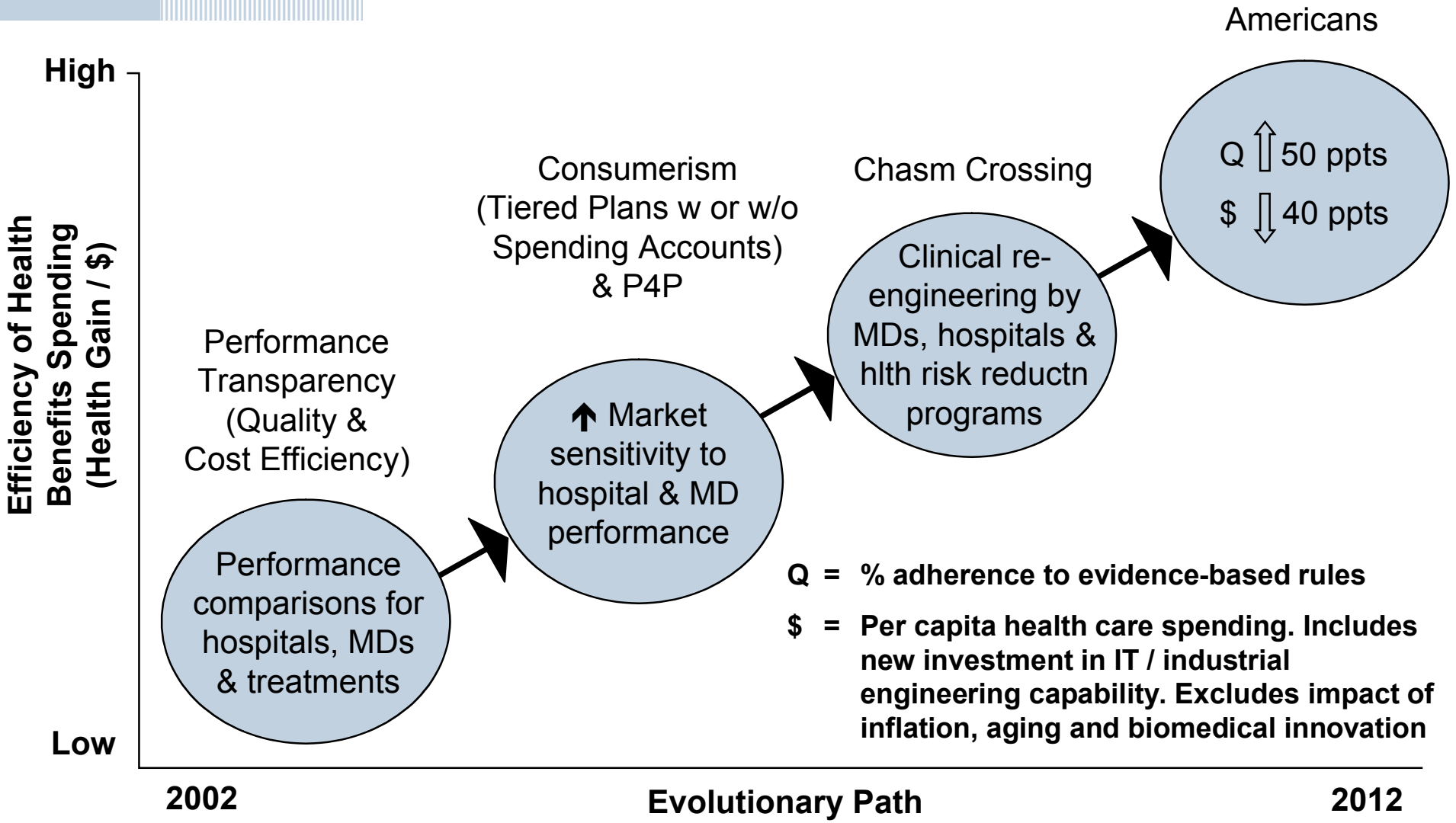
Source: State of Washington Office of Financial Management (July 2005)

Large Employer Health Care Strategies

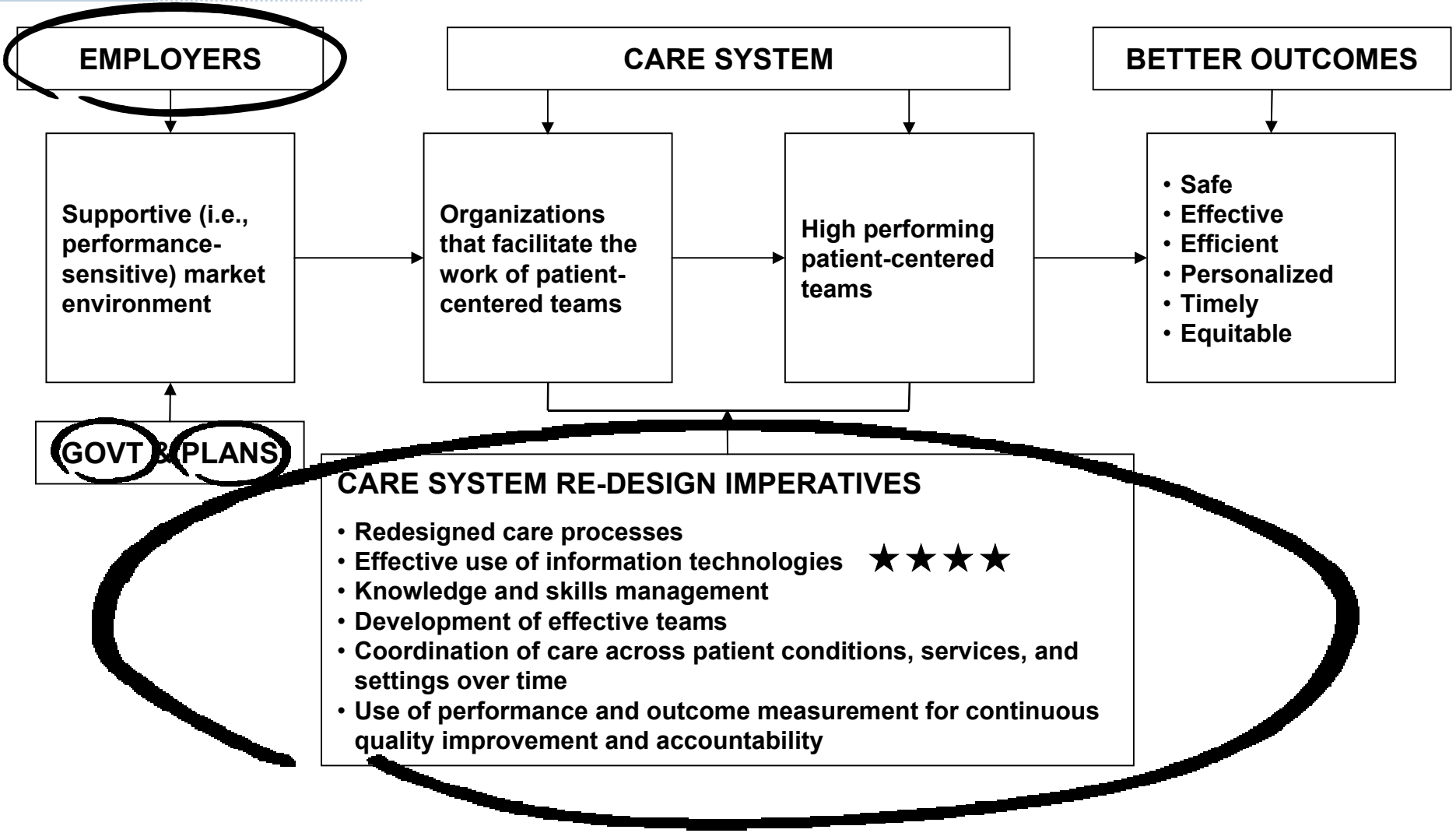


Source: Mercer Human Resource Consulting

A Near-Term Vision that Benefits All Stakeholders



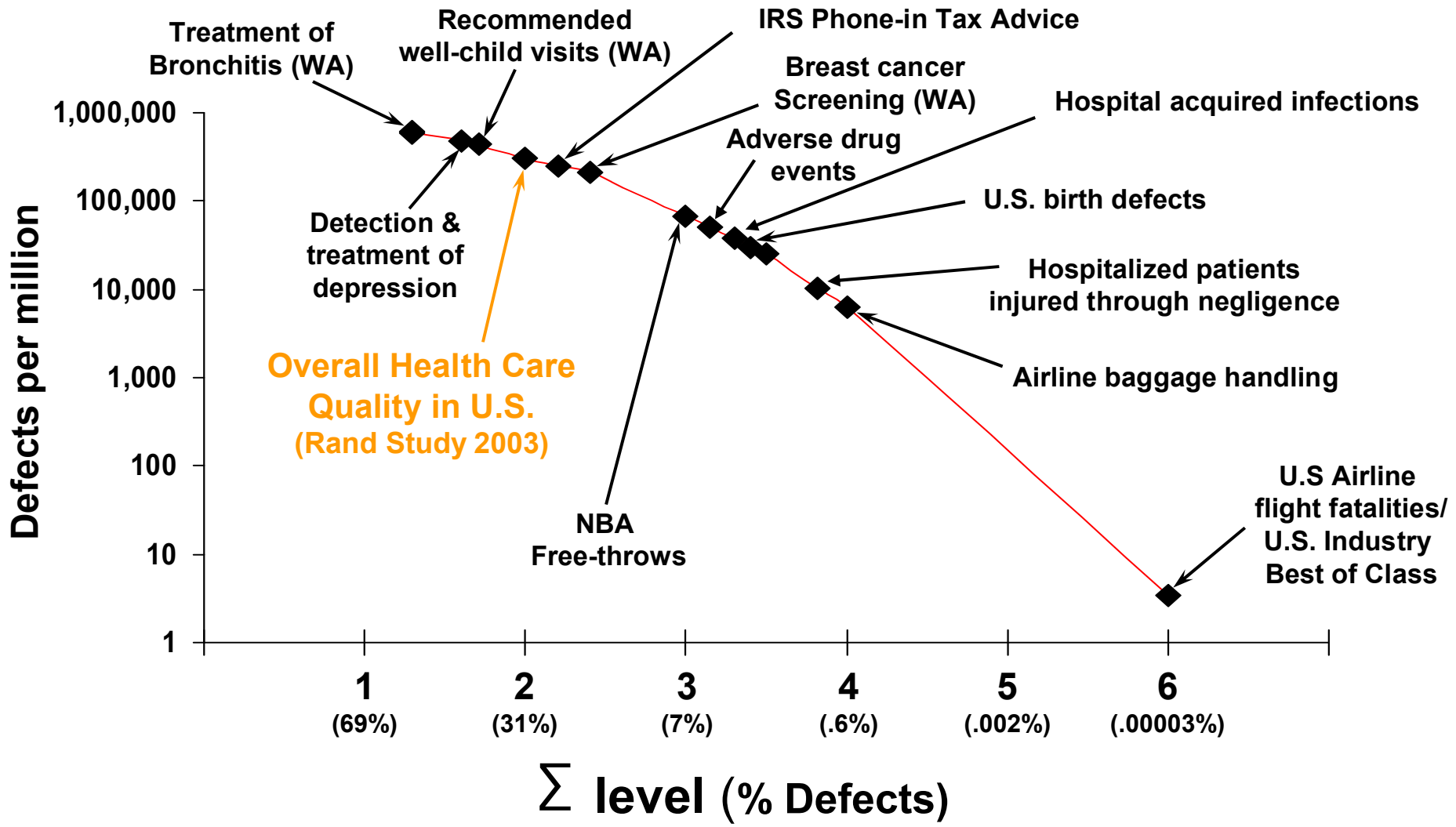
A Similar Vision from the Institute of Medicine



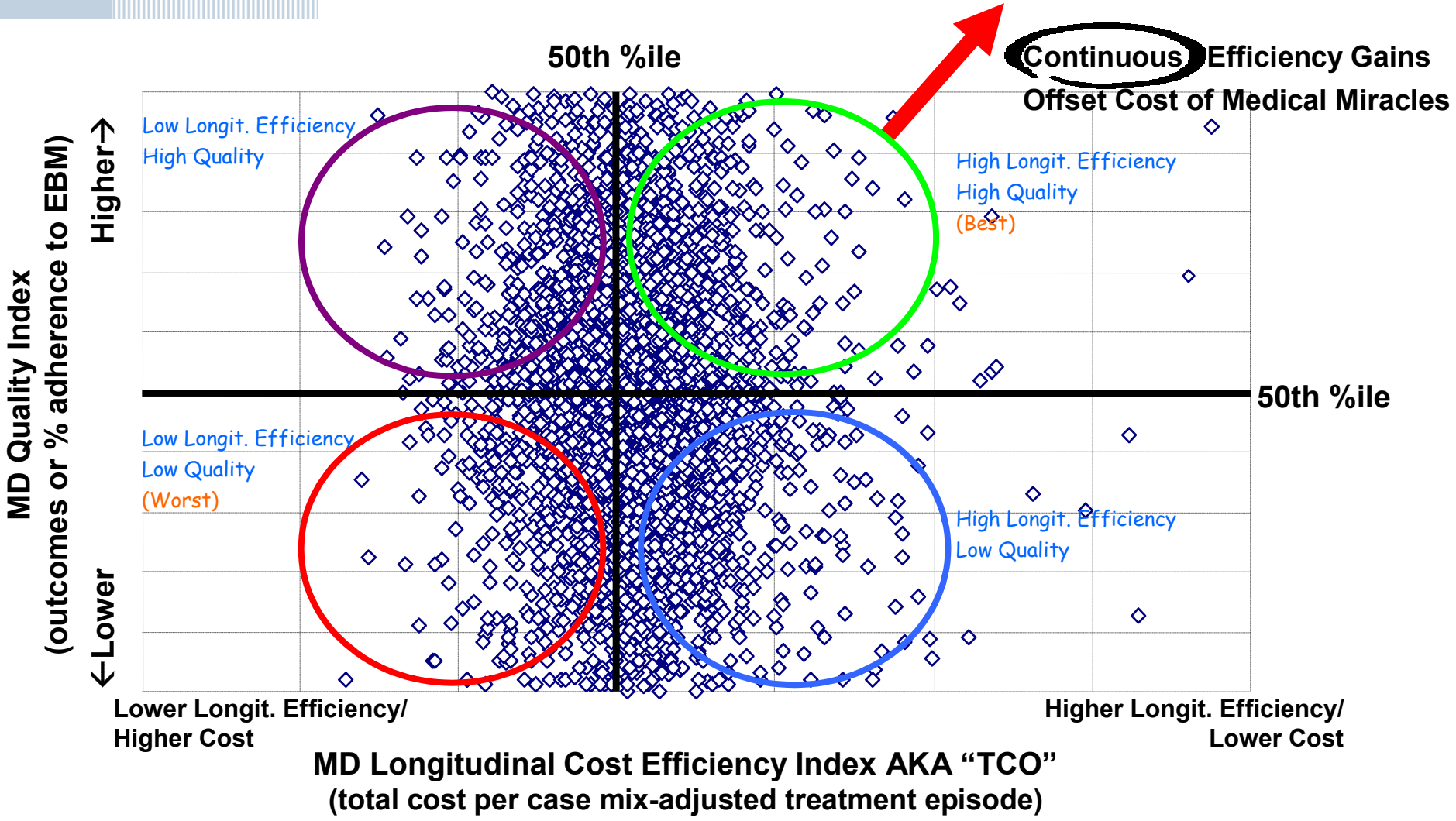
Source: Adapted by Arnie Milstein, M.D., from Crossing the Quality Chasm, IOM, 2001

Health Care Quality Defects Occur at Alarming Rates

Sources: modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint; Premera 2004 Quality Score Card; March of Dimes



Incentivizing Robust Re-Engineering of Health "Production" is the Only Infinite Method of Stabilizing Health Care Spending

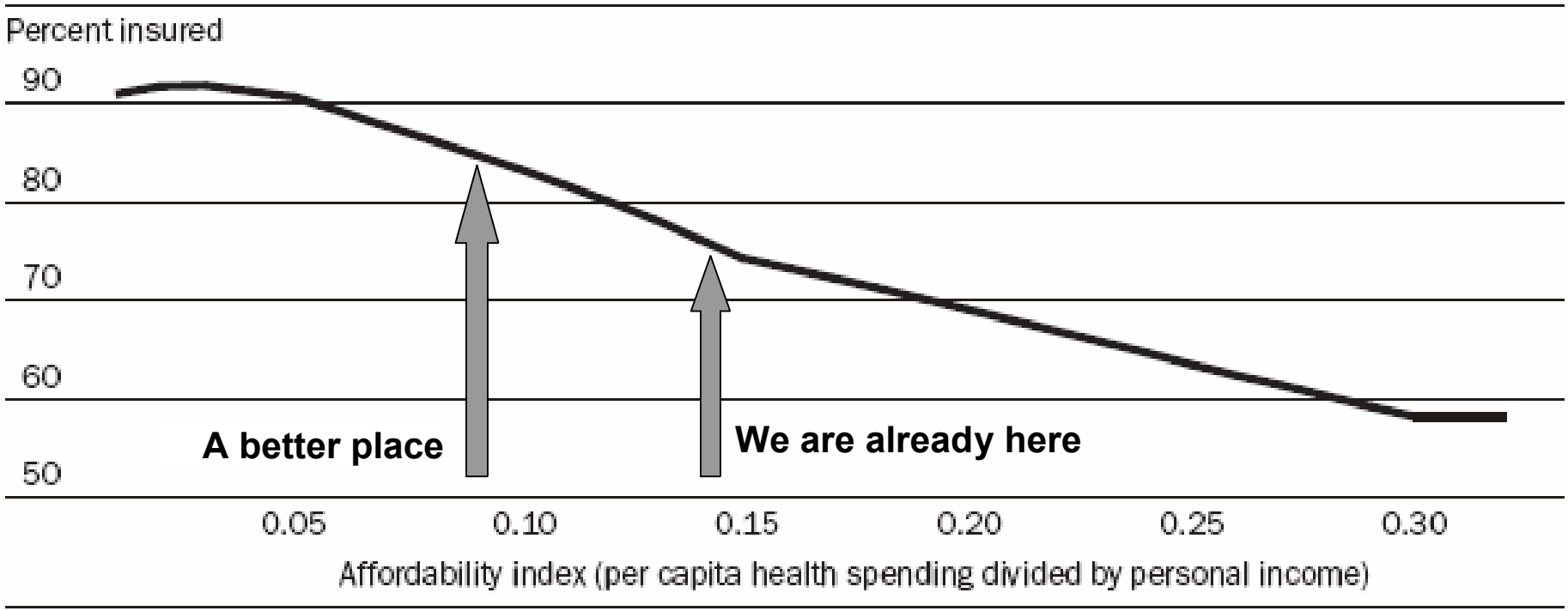


Adapted from Regence Blue Shield

How Much Would a 40% Gain in the Efficiency of the Health Industry Reduce Uninsurance?

Predicted Percentage Insured Among Workers, By Affordability Index

From "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," by Gilmer and Kronick, Health Affairs, April 2005



SOURCES: Authors' analysis of Current Population Survey (CPS), March supplements, Annual Demographics Files, 1980–2003, except 1981; and Centers for Medicare and Medicaid Services, National Health Accounts, 1979–2002.

Governor's Work Group on Health Care Quality and Cost

Initatives

1. Centralized, collaborative, evidenced based set system to set priorities and determine what the State will pay for.
2. Effectively manage the 'High Opportunity' populations insured or sponsored by the State – 5%-50% population
3. Promote the transparency of health plan and provider performance.
4. Prevention and Wellness for State Employees and Beneficiaries
5. Encourage technology improvements in patient/provider information

<u>Others</u>

- Improve PEBB procurement to improve quality and cost.
- Medicaid Cost Containment
- Improve the insurance market for small employers and individuals
- Reduce the impact of State administrative impacts on providers
- Explore the creation of an Institute for Clinical Performance Improvement

What's Wrong? Quality Performance Is Too Low

- **RAND: Americans get evidence-based care only 55% of the time**
- **IOM: up to 98,000 Americans die each year due to avoidable medical errors**
- **NCQA: up to 79,000 Americans die each year due to quality gaps**
- **CDC: 2 million patients acquire infections in the hospital each year => 90,000 die**

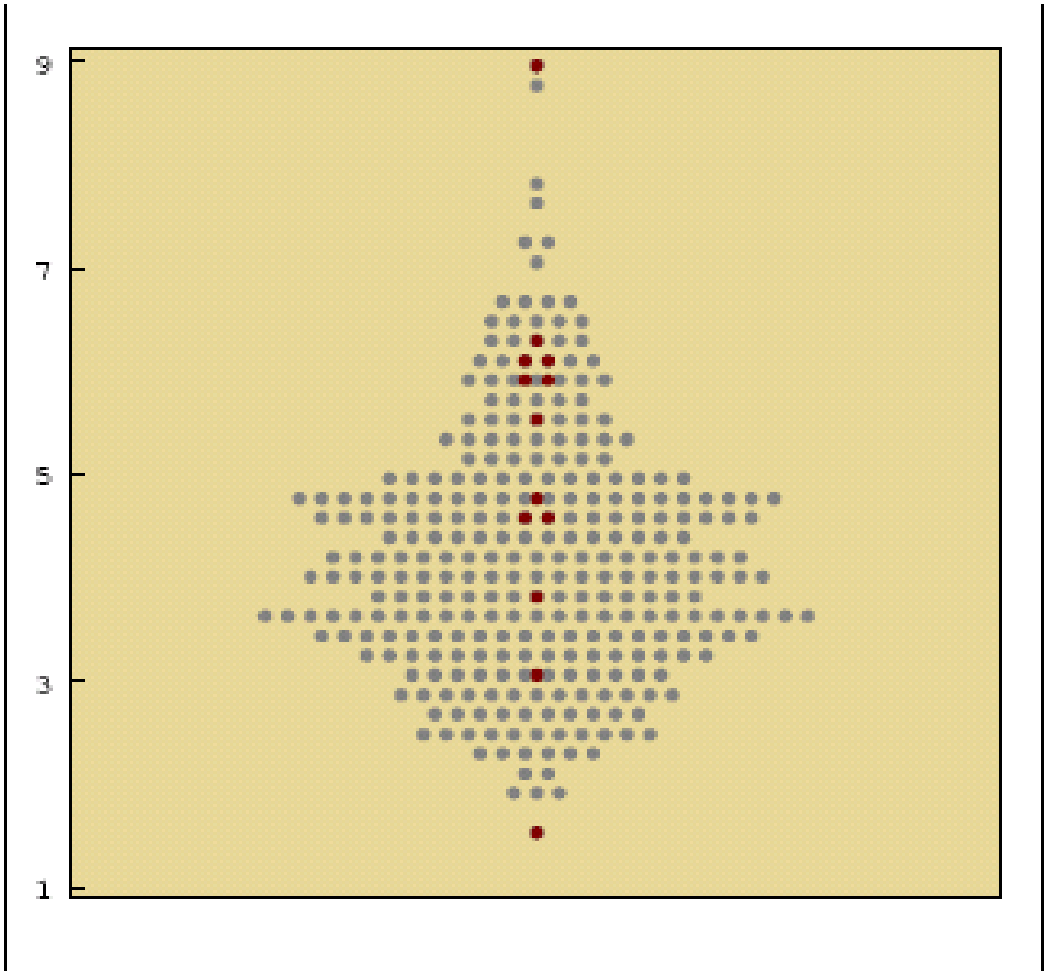
Preventing Complications and Premature Death

Patients get recommended care only half of the time; consequences are avoidable.

Condition	Shortfall in Care	Avoidable Toll
Diabetes	Average blood sugar not measured for 24%	2,600 blind; 29,000 kidney failure
Hypertension	< 65% received indicated care	68,000 deaths
Heart Attack	39% to 55% didn't receive needed medications	37,000 deaths
Pneumonia	36% of elderly didn't receive vaccine	10,000 deaths
Colorectal Cancer	62% not screened	9,600 deaths

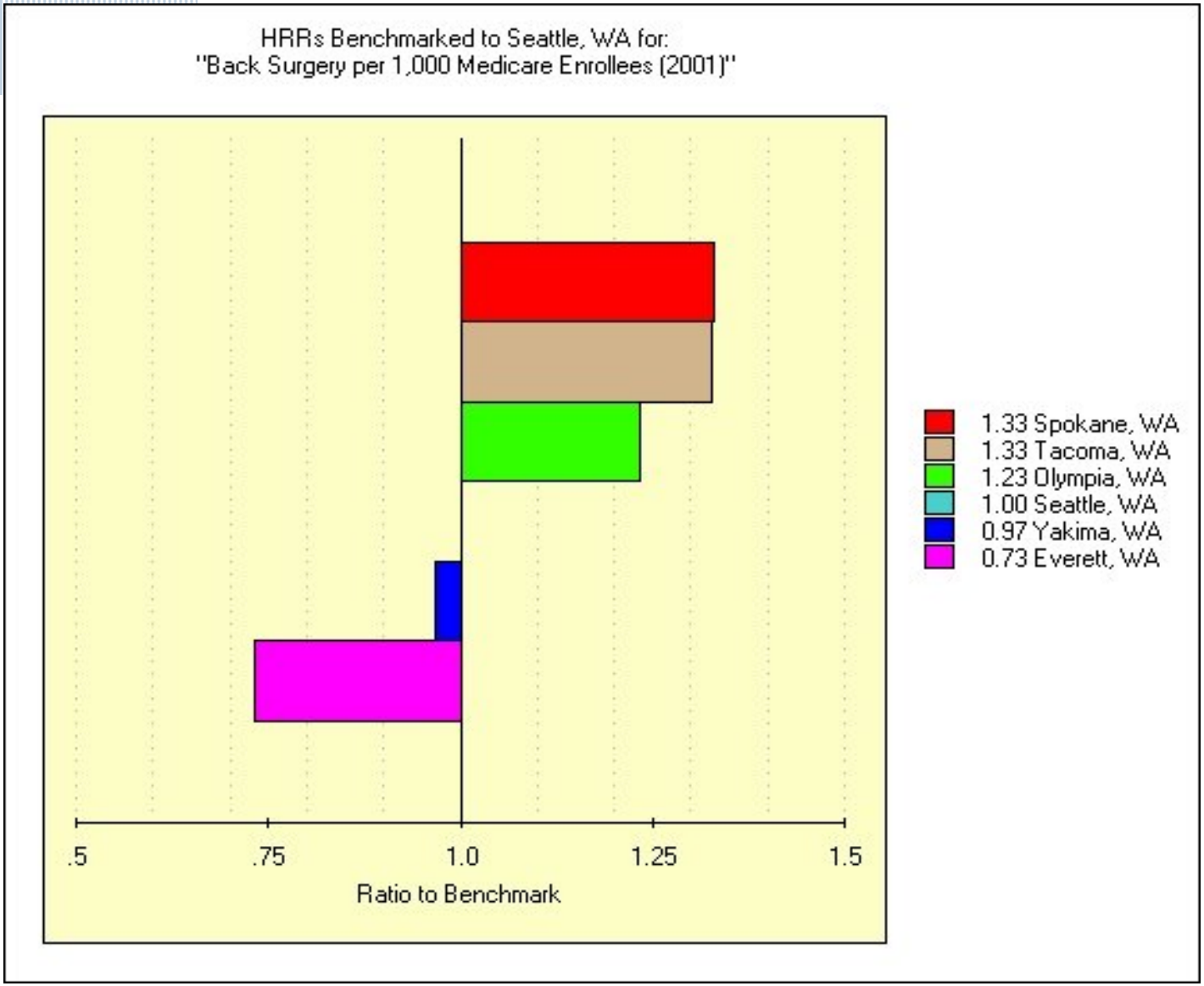
Source: Elizabeth McGlynn et al, RAND, 2004

Surgery for Back Pain



Bend, OR	9.0
Eugene, OR	6.2
Portland, OR	6.1
Salem, OR	5.9
Spokane, WA	5.8
Medford, OR	5.8
Tacoma, WA	5.4
Yakima, WA	4.6
Seattle, WA	4.5
Olympia, WA	4.5
Everett, WA	3.8
Anchorage, AK	3.0
Honolulu, HI	1.3

Back Surgery



Sample Process Reengineering in Dr's Office
An Initial "Rebuild" of an Ophthalmology Visit

- **Before** — **"we're doing everything we can think of… we need more money!"**

Traditional model
1 assistant/MD
Staff poorly trained
2 rooms/MD

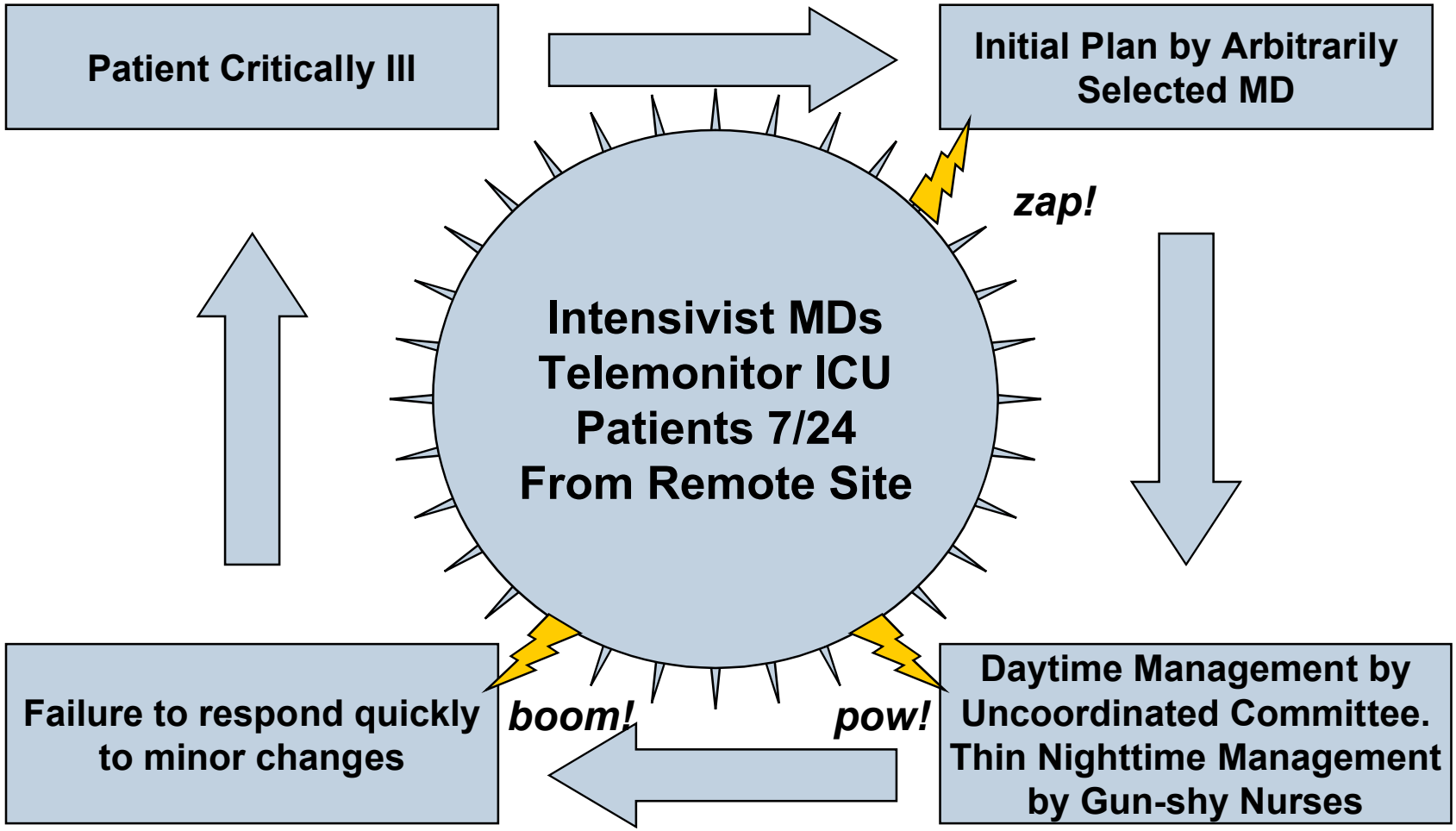
22 patients/day/MD
3 month wait for consult
Patient Satisfaction = 63%
Provider Satisfaction = 90%
$60 per visit
$22.31 per beneficiary/year

- **After** — **"we're doing what we didn't know about before… we need less money!"**

Engineered model
3 assistants/MD
Staff highly trained
4 rooms/MD

50 patients/day/MD
No wait for consult
Patient Satisfaction = 85%
Provider Satisfaction = 94%
$43 per visit
$14.91 per beneficiary/year

Sample Process Reengineering in Hospital
An Initial "Rebuild" of an ICU Stay



The Bottom Line: 54% reduction in mortality and 21% reduction in costs in average hospital. 20% and 20% in a "top" hospital.